

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028065

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 139 Primary Registration District No. 5536 Registrar's No. 53

FILED JUL 29 1963

1. PLACE OF DEATH a. COUNTY HOLT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY HOLT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN LEWIS TWP.		c. CITY OR TOWN MOUND CITY	
Length of stay in 1b 2 mos.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION PLEASANT HILL NUR. H.		d. STREET ADDRESS (If outside, give location) (If outside, give location)	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) PEARL ELIZABETH JUDY			4. DATE OF DEATH Month July Day 25 Year 1963		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/9/1887	9. AGE (last birthday) 76	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (City and state or country) HOLT COUNTY Mo.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME JOHN JUDY		13b. MOTHER'S MAIDEN NAME HANNAH WAMPLER	
14. NAME OF HUSBAND OR WIFE NONE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT MRS. ESTHER HAYNES, MOUND CITY, Mo.		Address			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia DUE TO (b) Cerebral Vascular Accident DUE TO (c) Brain		INTERVAL BETWEEN ONSET AND DEATH 4 hrs
---	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
---	--	---	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour 12:30 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION MOUND CITY, Mo.	COUNTY MO.	STATE MO.
21. I attended the deceased from July 1959 to July 25, 1963 and last saw her July 25, 1963 Death occurred at 12:30 A on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE James H. Crawford M.D.	(Degree or title)	22b. ADDRESS MOUND CITY, Mo.	22c. DATE SIGNED 7/27/63
---	-------------------	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 7-27-1963	23c. NAME OF CEMETERY OR CREMATORY NORTH BETHEL	23d. LOCATION (City, town, or county) (State) MOUND CITY, Mo.
--	-------------------------------	---	---

24. FUNERAL DIRECTOR JAMES H. CRAWFORD	ADDRESS MOUND CITY, Mo.	25. DATE RECD. BY LOCAL REG. 7-27-1963	26. REGISTRAR'S SIGNATURE James H. Crawford
--	-----------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300 Rev. 4/59	DATE AMENDED	
1 0440		
2 0440		
3		
4 1		
5 0		
6		
7 0		
8 2		
9 331X		
10		
11		
12 86-0		
13 1-0		

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

James H. Crawford

Licensed Embalmer No. 4796

P. O. Address

Mound City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.